

***Virginia Workers' Compensation Commission***  
***Request for Mediation***

**VWC/JCN File Number:** \_\_\_\_\_

**Date of Injury:** \_\_\_\_\_

**Person Requesting Mediation:**

☐ Claimant

☐ Claimant Attorney

☐ Claims Administrator

☐ Claims Administrator Attorney

☐ Other: \_\_\_\_\_

**Name:** \_\_\_\_\_

**Phone #:** (\_\_\_\_) \_\_\_\_\_

**Fax #:** (\_\_\_\_) \_\_\_\_\_

**Address: (Number, Street, Apt., City, State and Zip)**

\_\_\_\_\_

\_\_\_\_\_

**Describe the issue that you believe should be the subject of the mediation:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**I consent to mediation of this matter by an employee of the Virginia Workers' Compensation Commission. I understand if one of the other parties objects to this request the matter will not be referred for mediation.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Mail or Fax this form to:**

**Marjorie Platt, Mediation Scheduler**

Virginia Workers' Compensation Commission

1000 DMV Drive

Richmond, Virginia 23220

**FAX: 1 (877) 502-9258**